COMMUNICABLE DISEASES/CONDITIONS AND RETURN TO SCHOOL GUIDELINES

PREPARED BY:
DIVISION OF EPIDEMIOLOGY/OFFICE OF COMMUNITY HEALTH SERVICES
MISSISSIPPI STATE DEPARTMENT OF HEALTH
THIRD EDITION - SEPTEMBER, 2000

TABLE OF CONTENTS

INTRODUCTION

School administrators and teachers are required to make frequent decisions regarding when children with communicable diseases/conditions should be allowed to attend or return to school. This booklet will help with these decisions. It contains information about the most common or important communicable diseases/conditions and how they are spread. Information is listed about the different times during which infectious agents may be transmitted from one person to another, and when it is usually safe for someone who has one of these conditions to return to school. The "return to school times" are based on the usual period of time that a person is considered to be contagious — ***not*** on the period of time that may be necessary for full clinical recovery from the signs or symptoms of an illness which may vary a great deal from person to person. We want children to be protected from contagious conditions but it is also our desire that no child be excluded from school longer than is necessary.

With the exception of tuberculosis (TB), the communicable diseases/conditions listed in this booklet do not require a note or release from the Mississippi State Department of Health (MSDH) for a child to return to school.

While this booklet will serve as a guide for school attendance of children with communicable conditions, the MSDH welcomes the opportunity to help with your decisions. You may contact your district health department office (see district map on page 11) or the Division of Epidemiology in Jackson to speak with a consultant. Also, arrangements may be made with your local or district health department for someone to speak to the faculty and staff of your school.

****

***** THIS booklet is NOT intended to be used to DIAGNOSE an illness or infection. It SHOULD NOT REPLACE a diagnosis by trained MEDICAL personnel. *****

DISEASE PREVENTION

While excluding children with communicable diseases from school helps prevent the spread of disease, there are basic disease prevention measures that should be taken on a routine basis. The MSDH recommends the following disease prevention practices:

HANDWASHING

It is the responsibility of the school system, as well as the family and community, to teach and promote good health and hygiene practices. Most experts would agree that **handwashing is the single most effective hygienic practice that prevents the spread of germs** in an institutional setting as well as in an individual's home. In order for a child to practice good handwashing while at school the MSDH recommends that warm running water, liquid soap and a sanitary method for drying hands (e.g., single-use disposable paper towels, warm air dryers) are made available. There should also be a means of providing some type of hand cleaner or individual, premoistened towelettes for cleaning hands in the event of a water system failure. Children should be encouraged to wash their hands especially before eating and after bathroom usage.

SAFE DRINKING WATER

The MSDH recommends that each school obtain water from a water system that meets the Mississippi Safe Drinking Water Act standards. It is also recommended that schools have a means for providing safe drinking water in the event of a break-down in the water system (e.g., providing bottled water during this time).

SCHOOL ATTENDANCE WHEN ILL

The MSDH recommends that schools **do not** implement policies that would encourage or require students to attend school when they are ill.

****

For educational material regarding personal hygiene, etc., contact the School Health Coordinator at the Mississippi State Department of Health, Division of Health Promotion/Education/Chronic Illness.

CHICKENPOX (VARICELLA)

Chickenpox is a highly infectious viral disease that begins with small red bumps that turn into blisters after several hours. The blisters generally last for 3-4 days and then begin to dry up and form scabs. These lesions (bumps/blisters) almost always appear first on the trunk rather than the extremities.

Mode of transmission: Airborne droplets of nose and throat secretions coughed into the air by someone who has chickenpox. Also, indirectly through articles freshly soiled with discharge from the lesions (blisters) and/or discharge from the nose and mouth (e.g., tissues, handkerchiefs, etc.).

Vaccine: A vaccine for chickenpox is available and is recommended for children after 12 months of age and for adolescents and adults who do not have a reliable history of chickenpox disease.

Return to school: Once the diagnosis has been made, determine the day that the lesions (bumps/blisters) first appeared. The child may return to school on the 6th day after the lesions first appeared or earlier if the lesions are **crusted and dry and no new ones are forming**. Keeping the child home until all the lesions are completely healed is unnecessary and results in excessive absence from class.

SHINGLES (VARICELLA ZOSTER)

Shingles (varicella zoster) is a reactivation of the chickenpox virus (varicella). After the initial infection with chickenpox, the virus continues to lie dormant (inactive) in a nerve root. We tend to think of the elderly and immunosuppressed individuals as the ones who have shingles; however, it can and does occur sometimes in children. The lesions or blisters of shingles resemble those of chickenpox and usually appear in just one area or on one side (unilateral) of the body and run along a nerve pathway. A mild shingles-like illness has been reported in healthy children who have had the chickenpox vaccine. This is a rare occurrence.

Mode of transmission: It is possible for someone who has never had chickenpox disease or the vaccine to get chickenpox by coming in contact with the fluid from the lesions of someone who has shingles. Shingles itself is not transmissible. A person who has shingles does not transmit chickenpox through the air as does someone who has chickenpox disease.

Return to school: The child who has shingles may attend school if the lesions can be covered by clothing or a dressing. If the lesions cannot be covered, the child should be excluded until the lesions are crusted and dry. **Thorough handwashing** is warranted whenever there is contact with the lesions.

FIFTH DISEASE (ERYTHEMA INFECTIOSUM)

This is an infectious disease characterized by a "slapped-face" (redness) appearance of the cheeks followed by a rash on the trunk and extremities.

Mode of transmission: Person-to-person spread by direct contact with nose and throat secretions of an infected person. Transmission of infection can be lessened by routine hygienic practices which include handwashing and the proper disposal of facial tissues containing respiratory secretions.

Return to school: Children with fifth disease may attend school if they are **free of fever**, since by the time the rash begins they are no longer contagious. The rash may come and go for several weeks. **Pregnant women** should consult their obstetrician if children in their class have fifth disease.

"FLU" (INFLUENZA)

Influenza is an acute (sudden onset) viral disease of the respiratory tract characterized by fever, headache, muscle aches, joint pain, malaise, nasal congestion, sore throat and cough. Influenza in children may be indistinguishable from diseases caused by other respiratory viruses.

Mode of transmission: Direct contact with nose and throat secretions of someone who has influenza - airborne spread by these secretions being coughed into the air.

Return to school: The student may return to school when free of fever and feeling well. The closing of individual schools has not proven to be an effective control measure. By the time absenteeism is high enough to warrant closing, it is too late to prevent spread.

HEAD LICE

This is an infestation of the scalp by small "bugs" called lice. They firmly attach egg sacs called "nits" to the hairs, and these nits are difficult to remove. Treatment may be accomplished with prescription or over-the-counter medicines applied to the scalp. Some products require a repeat treatment one week after the first one to kill lice that hatch from nits not killed by the first treatment. Other products require only a single treatment.

Mode of transmission: Direct contact with an infested person's hair (head-to-head) and, to a lesser extent, direct contact with their personal belongings, especially shared clothing and headgear. Head lice do not jump or fly from one person to another, but they can crawl very quickly when heads are touching.

Return to school: The child may return to class without a physician's release after the first treatment has been given. **(See Appendix A - "Recommendations For The Control of Head Lice In Schools")**

HEPATITIS A

Hepatitis A is an infectious viral disease characterized by jaundice (yellowing of eyes and skin), loss of appetite, nausea, and general weakness.

Mode of transmission: Hepatitis A virus is found in the stool of persons with hepatitis A. The virus is usually spread from person to person by putting something in the mouth that has been contaminated with the stool of an infected person; for this reason, the virus is more easily spread under poor sanitary conditions, and when good personal hygiene, especially good handwashing, is not observed. Rarely, the virus is contracted by drinking contaminated water or by eating raw seafood (e.g., raw oysters) that has been collected from contaminated waters. School room exposure generally does not pose a significant risk of infection, and treatment of school contacts is not usually indicated.

Return to school: Children may return to school one week after the onset of jaundice or one week after the onset of other signs and symptoms if no jaundice is present.

HEPATITIS B

Hepatitis B is an infectious viral disease characterized by loss of appetite, abdominal discomfort, jaundice (yellowing of eyes and skin), joint aches, and fever in some cases. There is no risk of transmission of hepatitis B in a normal classroom setting unless a person who is infected with hepatitis B is bleeding. Since hepatitis B and HIV/AIDS are both transmitted through blood exposure, the precautionary measures for HIV/AIDS would also apply to hepatitis B. (See HIV/AIDS on page 6)

Mode of transmission: The most common mode of transmission is through having sex with someone who has the virus; however, it can be transmitted when infected blood enters the body through cuts, scrapes or other breaks in the skin. Injecting drug users are at risk when they share needles with an infected person. It is also possible for infected pregnant women to transmit the virus to their babies during pregnancy or at delivery.

If an exposure to a person who is infected with hepatitis B has occurred, the person exposed should be referred to his/her physician since hepatitis B vaccine and hepatitis B immune globulin may be indicated.

HEPATITIS C

Hepatitis C is also a viral disease that affects the liver. Again, hepatitis C should pose no risk of exposure in the normal classroom setting unless the infected person is bleeding. There is no vaccine available for hepatitis C at this time. Since it is also transmitted through blood exposure, the same precautionary measures for hepatitis B and HIV/AIDS would apply to hepatitis C. (See HIVAIDS on page 6)

HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION/ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

Mode of transmission: The most common mode of transmission is through having sex with someone who has the virus; however, it can be transmitted when infected blood enters the body through cuts, scrapes or other breaks in the skin. Injecting drug users are at risk when they share needles with an infected person. It is also possible for infected pregnant women to transmit the virus to their babies during pregnancy or at delivery. Although HIV and hepatitis B are transmitted in the same way, HIV is much more difficult to transmit from one person to another than hepatitis B.

HIV infection in children causes a broad spectrum of disease manifestations and a varied clinical course. No cases of HIV transmission in school have been reported, and current epidemiologic data do not justify excluding children with HIV infection from school or isolating them in school to protect others. Because blood exposures from fights, unintentional injuries, nosebleeds, shed teeth, menstruation and other causes may occur at school, all schools should be prepared to handle blood and blood-containing body fluids using the principles of universal precautions (treating blood and body fluids of all persons as infectious). Supplies of gloves, disposable towels and disinfectants should be readily available. There is no evidence that HIV, hepatitis B or hepatitis C is transmitted through tears, perspiration, urine or saliva unless these body fluids contain **visible** blood.

Participation in some contact sports may increase a child's risk of exposure to blood: forceful contact with hard surfaces, equipment, or other players may result in laceration or abrasion; and close player-to-player contact may lead to direct exposure to another person's blood. Nonetheless, the risk of HIV transmission during sports is probably low. However, because of the potential risk to the athlete's own health and the theoretical risk of HIV transmission to others during contact sports, athletes with HIV infection interested in participating in contact sports such as wrestling, boxing or football should be evaluated on a case-by-case basis. The Mississippi State Department of Health is available for consultation in these situations.

IMPETIGO

This is a contagious skin disease characterized by spreading pustular lesions (sores with pus) and should receive medical treatment. This is quite important to avoid the risk of complications involving the heart and kidneys.

Mode of transmission: Skin-to-skin contact with the sores.

Return to school: The child may return to class 24 hours after treatment has been started. Lesions that are still oozing and are on exposed skin surfaces should be covered.

MEASLES

This is a serious viral infection characterized by a rash (red, flat lesions) starting on the head and neck, which enlarge and coalesce (run together), and spread to the trunk, then to the extremities. Other symptoms include a high fever, conjunctivitis (red, inflamed eyes), cough and nasal congestion. The Health Department must be notified on first suspicion.

Mode of transmission: Direct contact with nose and throat secretions of an infected person. May be airborne by droplets of these secretions coughed into the air. Tiny droplets can be suspended in the air for two hours or more. Measles is very easily spread.

Return to school: The child may return to school when free of fever and the rash is fading (this usually takes 5 to 7 days).

MENINGITIS

Meningitis is an inflammation or infection of the meninges (the membranes that cover the brain and spinal cord). Meningitis can be caused by a variety of organisms or germs. These germs are most commonly spread by direct contact with nose and throat secretions from an infected person. Most people exposed to these germs do not develop meningitis or serious illness. Some people may carry a particular germ and have no symptoms at all. Anyone exhibiting signs and symptoms of meningitis (e.g., severe headache, fever, vomiting, stiffness and pain in the neck, shoulders and back, drowsiness) should seek medical attention promptly.

Meningitis is a reportable disease. The MSDH evaluates each case individually to determine what public health intervention, if any, might be required. The two types of meningitis that require public health intervention most often are caused by the organisms Haemophilus influenzae type b and Neisseria meningitidis (meningococcal).

Return to school: The individual may return to school whenever he or she has been released by their personal physician.

MONONUCLEOSIS (INFECTIOUS)

This is an infectious disease characterized by fever, sore throat, swollen glands in the neck area, and generalized weakness. Intimate contact, such as kissing or sharing drinking glasses or straws, is usually required for transmission.

Mode of transmission: Person-to-person spread by direct contact with the saliva of an infected person.

Return to school: The child need not be excluded from class, unless requested for medical reasons, but may return when feeling well enough. Children should not share food or utensils.

MUMPS

This is an infectious viral disease that is characterized by swelling and pain of the salivary glands.

Mode of transmission: Person-to-person spread by direct contact with the saliva of an

infected person.

Return to school: Children may return to school 9 days after the beginning of the salivary gland swelling.

"PINK EYE" (CONJUNCTIVITIS)

This is an infectious disease characterized by redness of the eye(s), excessive tearing, itching, and discharge. Some cases may require antibiotics; therefore, a physician should be seen.

Mode of transmission: Contact with discharges from the eye, nose or throat of an infected person. Also, from contact with fingers, clothing and other articles such as shared eye make-up applicators that have been contaminated with the discharge.

Return to school: Children may return to school after a physician has been seen, or when redness/discharge is improving.

RINGWORM

Ringworm any place except on the scalp or under the nails can be successfully treated with several over-the-counter medicines. When the lesions (red, circular places) are found, it is reasonable to send a note home with the child indicating a need for treatment.

Mode of transmission : Direct skin-to-skin contact or indirect contact (e.g. toilet articles such as combs and hair brushes, used towels, clothing and hats contaminated with hair from infected persons or animals). Ringworm is a fungus, not a worm.

Return to school: The child may return to school after treatment has been started. There is no need for the parent to make a special trip to school to get the child and prolonged absence from class is unnecessary.

Ringworm of the **scalp** is characterized by inflammation, redness, and hair loss and does not respond to over-the-counter medicines; therefore, the student should see his/her physician. Students should be discouraged from sharing combs, brushes, and hats because these are possible sources for infection. Medical treatment is also indicated for ringworm of the **nails.**

Return to school: The child may return to school as soon as treatment, which usually lasts several weeks, has been started.

SCABIES

Any child with evidence of severe itching especially around webs of fingers, wrists, elbows, under arms and belt line should be referred to his/her physician. Scabies requires treatment by prescription drugs.

Mode of transmission: Direct skin-to-skin contact with an infested person.

Return to school: The child may return to school as soon as treatment has been administered. It must be noted that itching may continue for several days, but this does not indicate treatment failure or that the child should be sent home.

"STREP THROAT" (STREPTOCOCCAL PHARYNGITIS) & SCARLET FEVER

Strep throat is a communicable disease characterized by sore throat, fever, and tender, swollen lymph glands in the neck. The child should see a physician to obtain prescription medication; this is quite important to avoid the risk of complications involving the heart and kidneys.

Mode of transmission: Direct or indirect contact (e.g., contaminated hands, drinking glasses, straws) with throat secretions of an infected person.

Return to school: The student may return to class 24 hours after treatment has been started if free of fever.

SCARLET FEVER

Scarlet fever is a streptococcal infection with a rash (scarlatinaform rash). It is most commonly associated with strep throat. In addition to the signs and symptoms of strep throat, the person with scarlet fever has an inflamed, sandpaper-like rash and sometimes a very red or "strawberry" tongue. The rash is due to a toxin produced by the infecting strain of bacteria.

Return to school: The treatment and exclusion criteria for scarlet fever would be the same as for strep throat.

TUBERCULOSIS (TB)

Persons diagnosed with TB infection are evaluated by the Mississippi State Department of Health on an individual basis.

Mode of transmission: Airborne droplets of respiratory secretions coughed or sneezed into the air by a person with active TB disease.

Return to school: Those who have a positive TB skin test ***only*** may attend school since they have no disease process that is contagious. **Persons diagnosed with active TB disease will need written permission from the Mississippi State Department of Health Tuberculosis Control Program to return to school.**

WHOOPING COUGH (PERTUSSIS)

Pertussis is a contagious disease characterized by upper respiratory tract symptoms with a cough, often with a characteristic inspiratory (breathing in) whoop. The child will need to see a physician to be treated with antibiotics. Furthermore, the contacts of the child will also need to be treated with antibiotics.

Mode of transmission: Direct or indirect contact (contaminated articles) with nose and throat secretions of an infected person or by inhaling droplets of these secretions coughed into the air.

Return to school: The student may return to school 5 days after treatment has begun.

PUBLIC HEALTH DISTRICTS

District I - 662.563.5603

District II - 662.841.9015

District III - 662.453.4563

District IV - 662.323.7313

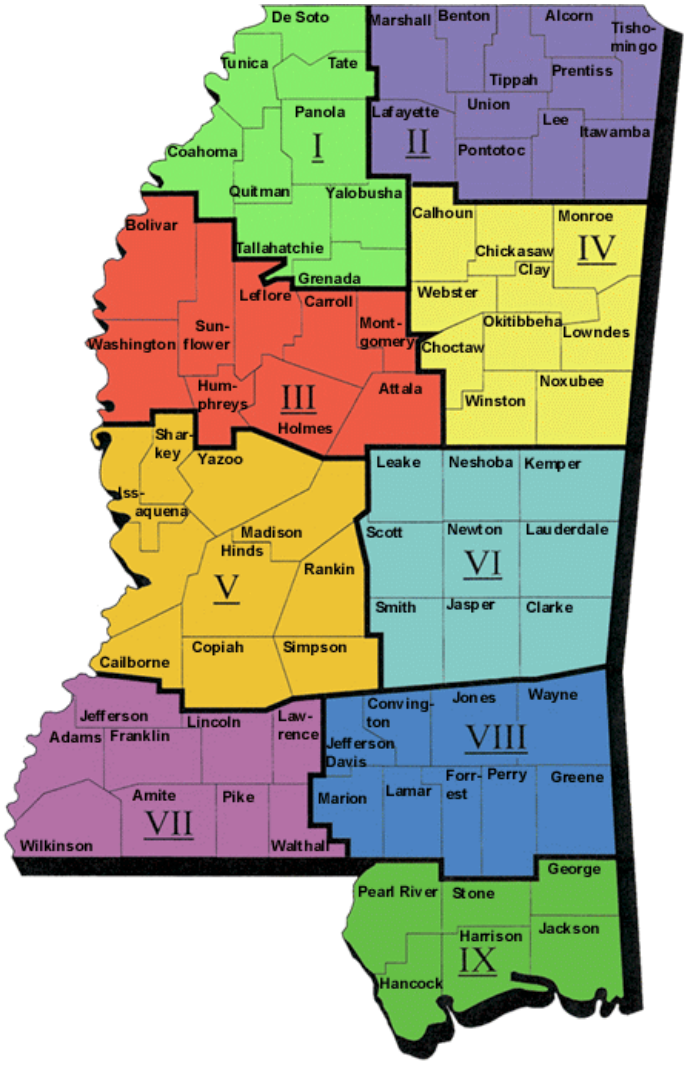
District V - 601.978.7864

District VI - 601.482.3171

District VII - 601.684.9411

District VIII - 601.544.6766

District IX - 228.831.5151



RECOMMENDATIONS FOR THE CONTROL OF HEAD LICE IN SCHOOLS

Head lice, *Pediculus humanus capitis*, are a common problem in school children in Mississippi. Although they do not transmit any human disease, they may be a considerable nuisance, and require conscious effort on the part of school officials and parents to control. **It should be understood that head lice can only be controlled in schools, not eliminated; they will occur sporadically, and will recur even after control efforts. The goal of control efforts is to reduce the problem and its impact, and minimize spread.**

Head lice are not a product of poor personal hygiene or lack of cleanliness, and their presence is not a reflection on the school or the family. More harm is probably caused by misconceptions about head lice than by the lice themselves.

1. IDENTIFYING INFESTED CHILDREN

By Screening: It is important to establish a regularly scheduled screening program for all students in grades K-6 and for older age groups if the problem arises. Screening should be done by the school nurse, teachers or other school staff after they have been instructed in the technique. The recommended times for screenings are: at the beginning of the school year, and after winter and spring breaks. Screening should occur more often if infested children are found.

By Individual Case: Throughout the year, any student suspected of having head lice (usually because he/she is scratching his/her head a lot) should be examined by the teacher, and if evidence of infestation is seen, re-examined by the school nurse or other "confirming" examiner. If infested, the child should be handled as described in Section 2, "HANDLING OF INFESTED CHILDREN."

If one child in a classroom is found to be infested, the whole class should be screened as described above.

2. HANDLING OF INFESTED CHILDREN

Exclusion: An infested child's parent/guardians should be notified that the child has been found to have head lice and must receive the proper treatment before returning to school. It is not necessary to remove the infested child from school before the end of the school day. Treatment and removal of nits are described in Section 3, "TREATMENT." Care must be taken not to embarrass or stigmatize the child.

Return to School: The child should return to school as soon as the parent/guardian provides evidence of treatment such as a note describing the treatment (e.g., "Johnny was treated with 'name of product used' according to package directions on 3/18/00.") or by presenting the empty bottle, with the label intact, of the product used. The treatment should be an approved **medical** treatment and **not** a home remedy. Examination of a treated child by a physician or the county health department is usually not indicated and unnecessarily involves health care personnel. **Nits (eggs) may still be seen even in an adequately treated child. This is not evidence of continuing infestation if the child has been properly treated and no adult lice are present.** According to the American Academy of Pediatrics, Red Book 2000, "no-nit" policies that require children be free of nits before returning to school **have not been proven effective** in controlling the transmission of head lice.

3. TREATMENT

Individual: Several effective pediculicides (lice-killing products) are available such as Nix®* (permethrin) creme rinse (10 minute hair rinse) which is available over the counter and has ovicidal (egg or nit-killing) capability. It is the only over-the-counter pediculicide covered by Medicaid. The pyrethrin/pyrinate products (10 minute shampoos) include such products as Rid®*, A-1000®*, R&C®*, Clear®* and Triple-X®* and are available over the counter at pharmacies. Kwell®* (1% lindane), a 4 minute shampoo, requires a prescription. Central nervous system toxicity with lindane has been documented with prolonged administration. Ovide®* lotion (Malathion 0.5%) has been re-approved by the Food and Drug Administration (FDA) as a prescription drug for the treatment of head lice infestation in the United States. Treatment with any approved pediculicidal (lice-killing) product should be adequate.

One treatment vs. two treatments: Most products require 2 treatments. An initial treatment will kill adult and larval lice, but will not kill all the eggs. **A second treatment 7 to 10 days later, after the eggs left by the first treatment have all hatched, will kill the newly hatched lice before they mature and reproduce and will complete the treatment process.** Nix®* requires only one treatment since it is an ovicidal (also kills the eggs or nits); however, a second treatment is desirable since the product is not likely to kill 100% of the nits. Ovide®* lotion is also ovicidal and requires a second treatment 7 to 10 days after the first one **only** if crawling lice are seen.

Parents/guardians should be required to furnish evidence of the second treatment no earlier than 7 days and no longer than I0 days after the first. The school may choose to require evidence of a second treatment even if the treatment is Nix®*. The same evidence, a note from parent/guardian or empty bottle with label, should be required.

Retreatment: Pediculicides should kill lice soon after application. However, in some situations (e.g., a person is too heavily infested, pediculicide is used incorrectly, reinfestation or possible resistance to the medication), the lice may still be present. Immediate retreatment with a **different class or type** of pediculicide is generally recommended if live lice are detected on the scalp 24 hours or longer after the initial treatment.

Removal of nits: The need to remove nits is somewhat controversial. However, removing the nits may prevent reinfestation by those nits hatching that may have been missed by the treatment. It may also decrease confusion about infestation when the person who has been treated is being re-examined for the presence of head lice, and it will avoid embarrassment to the infested child. Nits may be removed by the use of a nit comb or by manually ("nit-picking") removing them. Most of the nits that are easily seen and more easily removed with the nit comb are those that are grayish-white in color, have grown out one or more inches on the hair shaft and have already hatched. The new, viable nits are closer to the scalp (within about 1/4 inch) and are more of a brownish color. These nits are firmly attached to the hair shaft with a glue-like substance. There are commercial products available to help loosen the glue-like substance for easier removal.

Family: Household members of a child with head lice should be examined for lice (by a family member who knows how or someone else knowledgeable about lice) and any infested persons treated as described above. **The one exception is any person over 2 years of age who shares a bed with the infested child should simply be treated presumptively**. If the child is less than 2 years of age, consult the child's physician for treatment recommendations. (The safety of head lice medications has not been tested in children 2 years of age and under.)

4. ENVIRONMENTAL CONTROL

Household: Clothing, cloth toys, and personal linens (such as towels and bedclothes used within the previous 48 hours by an infested person) can be disinfected by washing in hot water and drying in the dryer using hot cycles. Non-washables should be dry cleaned, or stored in air-tight plastic bags for 2 weeks. Spraying with insecticides is usually not necessary. If there are cloth surfaces, such as furniture or carpet, with which the infested person's hair has had extensive contact, they should be vacuumed thoroughly.

School: Children should not be allowed to share hair ornaments, brushes or combs. Hats, coats, scarves and the like should be hung or placed individually for each child and not stacked or hung on top of those belonging to other children. Wall hooks, if used, should be far enough apart that garments hung on adjacent hooks do not touch. Sometimes plastic bags with draw strings are hung to contain garments if hooks are not far enough apart. Gym lockers used by more than one child should be assigned to the same users at each gym period to minimize the number of children using a locker. Headgear, including headsets, should be removed from use if lice are present in the class. If lice are an ongoing problem, headgear and headsets should be stored in an air-tight plastic bag for 2 weeks and not reused until the problem is resolved. Carpeted areas in classrooms should be vacuumed frequently and thoroughly. Lice killing sprays are generally unnecessary. Fumigation of classrooms or buses is not indicated.

5. ROLE OF THE HEALTH DEPARTMENT

The local health department can provide instruction for principals and other staff designated by the school in how to examine for and recognize head lice. These staff can in turn instruct others, including classroom teachers, in the technique. A nurse or doctor is not necessary to identify head louse infestation. Principals should contact their local health department or the district public health office to arrange for instruction and/or reinstruction as needed.

Children should not be sent routinely to the health department to be "checked" or given a note before returning to school (see Section 2, "Return to School"). This only inconveniences the parents and does not contribute to controlling head lice.

According to Section 41-79-21 of the Mississippi Code of 1972, as amended:

> "If a student in any public elementary or secondary school has had head lice on three (3) occasions during one (1) school year while attending school, or if the parent of the student has been notified by school officials that the student has had head lice on three (3) occasions in one (1) school year, as determined by the school nurse, public health nurse or a physician, the principal or administrator shall notify the county health department of the recurring problem of head lice with that student. The county health department then shall instruct the child's parents or guardians on how to treat head lice, eliminate head lice from household items, and prevent the recurrence of head lice." The law also allows the health department to charge the child's parents or guardians a fee for services.

The school should designate the school nurse, teachers or other staff to be "confirming examiners" who will refer children to the health department.

To refer a child to the health department for this purpose, the attached form should be completed and sent with the child to the local health department. The examiner should notify the public health nurse by telephone of the referral so that the nurse will be expecting the child.

Questions about control methods, specific treatments, or special problems can be addressed to the local health department, the district public health office, or to the Office of Community Health Services - Division of Epidemiology, State Department of Health in Jackson.

****

(***Use of specific product names is for example purposes only, and is not intended as endorsement of specific brands over others.)

SAMPLE LETTER TO PARENTS/GUARDIANS

Dear Parent or Guardian:

Your child _____ has been found to have head lice. Head lice do not transmit disease and they are not a result of lack of cleanliness. School age children get them commonly, sometimes more than once.

You should consult a pharmacist or your child's physician for a recommendation as to which of several effective products to use to treat your child. **As soon as you have treated your child with an approved pediculicidal (lice-killing) product, he or she may return to school**. To be readmitted to school, **your child needs a note from you** stating the name of the product used and the date of use or send the empty bottle, with the label on it, of the product used to the school.

Most products must be used twice, once to start and again not less than 7 days or more than 10 days after the first treatment. Your child need not miss any school after the first treatment, but if the product that you use requires a second treatment, **you <u>must</u> send a second note** with your child one week to 10 days after the first treatment stating the date of the second treatment and the product used.

There are 3 steps in the successful management of head lice:

1. Treatment (killing the lice with an approved medical treatment) - It is very important to follow the instructions given by your physician when using prescription medication. If you use over-the-counter medication, you should follow the package directions. The other members of your family should be checked for head lice and treated if they are found to have them. Persons over 2 years of age who sleep in the same bed with the infested child should be treated regardless. For children less than 2 years of age, consult the child's physician for treatment recommendations.

2. Removal of the nits - The Mississippi State Department of Health recommends that you attempt to remove the nits to avoid reinfestation by those nits hatching that may have been missed by the treatment. The nits can be removed by dividing the hair into sections and working each section separately. Look for small grayish-white or yellowish-brown specks that are attached to the hair shaft close to the scalp. Nits are attached to the hair shaft very firmly with a glue-like substance and are not easily brushed out. They must be picked out with the fingernails or combed with the nit comb that usually comes with the lice-killing product. This can be done outdoors under bright sunlight or indoors with a good reading lamp as nits are sometimes hard to see.

3. Environmental control - Clothing and personal linens (such as towels and bedclothes used by infested persons) should be machine washed (use hot water) and dried (on hot); non-washables can be dry cleaned or stored in an air-tight plastic bag for 2 weeks. Cloth-covered furniture and carpet that have been in extensive contact with an infested person's head should be thoroughly vacuumed. Lice-killing sprays are generally not necessary.

Principal _____ Date _____